PRINTED: 01/09/2014 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		LETED
		157223	B. WING				C 03/2014
	ROVIDER OR SUPPLIER  E HOME HEALTH			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 VANSVILLE, IN 47725	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	;	G	000			
	This was a Federal hinvestigation survey.	nome health complaint					
		1801; Substantiated, federal of the allegation are cited. s are also cited.					
	Survey Date: 1-3-14						
	Medicaid Vendor #:	100265610A					
	Surveyor: Vicki Harn	non, RN, PHNS					
	Agency census:						
	198 skilled 0 home health aide o 0 personal services	nly					
G 158	January 9, 2	e Elder, MSN, BSN, RN 2014 E OF PATIENTS, POC,	G	158			
		n plan of care established wed by a doctor of medicine, ric medicine.					
	Based on clinical recreview and interview, visits, procedures, an provided in accordance (#s 1, 2, 3, and 4) of 4	not met as evidenced by: cord and agency policy the agency failed to ensure ad treatments had been ce with physician orders in 4 4 records reviewed creating all of the agency's 198					
ARORATORY I	NIRECTOR'S OR PROVIDED!	SLIPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN005940

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		COMPLETED			
		157223	B. WING		C 01/03/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725	1 01/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
G 158	Continued From pa	ge 1	G 15	8	
	The findings include	:			
	care established by certification period ( states, "SN [skilled week for 8 weeks] . [medication] regime dosage, se [side eff	umber 1 included a plan of the physician for the 0-17-13 to 12-16-13 that nurse] 1w x 8 [1 time per to assess med n knowledge including ects], name, route, frequency, erse reactions, compliance/set			
	received 13 different Director of Nursing, 1-3-14 at 10:05 AM, the nurse was to fill	are identified the patient t oral medications daily. The employee A, indicated, on the plan of care did indicate the patient's medication 13 different medications on a			
	failed to evidence the B, had filled the pation ordered. The record	e visit note dated 12-10-13 ne registered nurse, employee ent's medication planner as d failed to evidence any other provided the week of 12-7-13 n planner.			
	care established by certification period 7 record evidenced th discharged from ser of care states, "SN Assess postural signs taken while th and then standing to pressure and pulse	umber 2 included a plan of the physician for the 7-20-13 to 9-17-13. The e patient had been vices on 9-17-13. The plan 1 week 2; 2 week 2; 1 week 6 vital signs [a series of vital e patient is lying down, sitting assess changes in blood rates] skilled assessment congestive heart failure]			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		157223	B. WING		01/03/2014
	ROVIDER OR SUPPLIER  E HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE  14649 HIGHWAY 41 NORTH, SUITE 200  EVANSVILLE, IN 47725	1 0 1/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
G 158	7-25-13,7-30-13, 8-8-7-13, 8-9-13, 8-10 8-14-13, evidenced signs while the patie evidence the nurse the patient was lying.  B. The record fa nurse had assessed weeks of 7-21-13 of the control of the co	visit notes, dated 2-13, 8-3-13, 8-4-13, 8-6-13, 0-13, 8-11-13, 8-13-13, and the nurse had taken the vital ent was sitting but failed to had taken the vital signs while g down or standing.  alled to evidence the skilled d the patient's weight the r 7-28-13.  of Nursing, employee A, 4 at 11:30 AM, the SN visit note the nurse had completed and that the nurse had not not's weight at least weekly as ry's usual practice for CHF  dentified the patient had allower legs. The record change order dated 8-9-13 wer leg - Apply petroleum oot. Place alginate strip over toes. Alginate square over wound area with ABDs, puble layer tubigrip E over toes  note dated 8-10-13 failed to ad applied the Alginate and over the dorsal foot as	G 15	8	
		ctor of Nursing, employee A, Lat 11:30 AM, the SN had not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157223	B. WING				C 03/2014
	ROVIDER OR SUPPLIER  E HOME HEALTH			1	STREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725	<u>,                                    </u>	00.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 158	ordered.  3. Clinical record nur care established by the certification period 10 record evidenced the discharged from serv of care states, "SN 2 assess med regin. Assess postural vita.  A. The plan of careceived 19 different basis. SN visit notes 11-21-13, 11-27-13, a evidence the SN had set-up as ordered.  B. SN visit notes, 11-13-13, 11-21-13, 1 12-13-13, evidenced signs while the patier evidence the nurse had the patient was lying.  C. A SN visit note the patient was lying.  C. A SN visit note the sylving.  C. A SN visit note the patient was lying.  C. A SN visit note the patient was lying.  A. Clinical record nur start of care order dates are order dates.  SN 1 day 1 to evaluate med regimen con.  A. The record inclinical rec	mber 3 included a plan of the physician for the 1-22-13 to 12-20-13. The patient had been ices on 12-20-13. The plan week 1; 1 week 8 SN to the solution of the patient or all signs."  The identified the patient or all medications on a daily and 12-5-13, failed to completed the medication  dated 120-30-13, 11-7-13, and 12-5-13, failed to completed the medication  dated 120-30-13, 11-7-13, 11-27-13, 11-27-13, 12-5-13, and the nurse had taken the vital of the was sitting but failed to ad taken the vital signs while down or standing.  Added 11-13-13 evidenced to patient's medications but the patient and/or caregiver and by the agency's own  The standard of the plan of the patient and/or caregiver and by the agency's own	G	158			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157223	B. WING				03/2014
	ROVIDER OR SUPPLIER E HOME HEALTH			1	STREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725		00,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 158	medication planner be medications had beer failed to evidence the were present as requipolicy.  B. The record includence the series of failed to include home care services.  C. The record includence the services.  C. The record includence the services.  C. The record failed to include for the SN visit.  D. The Director of indicated, on 1-3-14 and include a resumpt for the 1-2-14 SN visit agency's computer sypaper orders had not services.  5. The agency's 2009 number 3011 states, furnished to clients care established and doctor of medicine, of chiropractic, ophthalm.  6. The agency's 2009 Medications" policy nimiled only pre-fill medipatients/caregivers are presence during this patients/caregivers are presence during this patients/caregivers are presence during this patients/caregivers.	checked the patient's box to ensure the in properly set up. The note patient and/or caregiver ired by the agency's own luded a resumption of care asment dated 12-24-13. The lean order to resume the luded a SN visit note dated ailed to evidence an order standard to evidence an order to read the look of care order or an order to the look of care order or an order to the look of care order or an order to the look of care order or an order to the look of care order or an order to the look of care order or an order to the look of look of care order or an order to the look of look		158			
	The plan of care deve	eloped in consultation with					

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER E HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725		71703/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 159	including mental state equipment required, prognosis, rehabilitate limitations, activities requirements, medic safety measures to prinstructions for timely any other appropriate.  This STANDARD is Based on clinical receive and interview plans of care had be of 4 records reviewe affect all of the agent.  The findings include:  1. Clinical record nuclare established by the certification period 10 included a verbal ord nurse services for the 12-16-13 to 02-13-14 evidence a plan of care quired items had be certification period 13.  2. Clinical record nustart of care order daskilled nursing and powere to be provided 12-10-13 to 02-07-14 evidence a plan of care order daskilled nursing and powere to be provided 12-10-13 to 02-07-14 evidence a plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere to plan of care order daskilled nursing and powere da	ers all pertinent diagnoses, us, types of services and frequency of visits, tion potential, functional permitted, nutritional ations and treatments, any protect against injury, or discharge or referral, and exitems.  Inot met as evidenced by: cord and agency policy, the agency failed to ensure en developed in 2 (#s 1 & 4) discreating the potential to cry's 198 current patients.  In the record failed to exit the continue the skilled exit to continue the skilled exit to continue the skilled exit that included all of the een established for the 2-16-13 to 02-13-14.  In the record failed to the exit that included a verbal that included a verbal that the continue the certification period that the record failed to the exit that included all of the exit	G 1	59		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157223	B. WING				03/2014
	ROVIDER OR SUPPLIER E HOME HEALTH			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725		00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 159	care had not been ge patients.  4. The agency's 2009 policy number 3026 s will be developed after least every sixty days dictates Plan of Coare, including pertine status, types of service visits, goals and interdiscipline, prognosis, functional limitations, nutritional requirements afety measures, instantial states, developed by the RN with the physician and members, is documents.	arsing, employee A, at 9 AM, the agency's "crashed" and that plans of enerated as a result for some "9 "Care Planning Process" states, "A written plan of care er admission and updated at 6 (60) or as client's condition care: The clinical plan of ent diagnoses, mental ces/equipment, frequency of ventions appropriate to each rehabilitation potential, precautions, activities, ints, medications, treatments,	G	159			
G 163	CARE  The total plan of care physician and HHA poseverity of the patient least once every 60 d there is a beneficiary significant change in change in the case-m discharge and return	condition resulting in a nix assignment; or a to the same HHA during the or more frequently when	G	163			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		157223	B. WING		C 01/03/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725	01/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
G 163	significant change in change in the case-r discharge and return 60 day episode.  This STANDARD is Based on clinical rereview and interview plans of care had be sixty (60) days in 1 (patients on service for creating the potential patients that receive days.  The findings include  1. Clinical record nucare date of 6-9-13. of care established to certification period 1 included a verbal ord nurse services for the 12-16-13 to 02-13-14 evidence the plan of the physician for the to 02-13-14.  2. The Director of Nindicated, on 1-3-14 computer server had had not been general patients.  3. The agency's 200 number 3011 states, is reviewed by the acconsultation with the	not met as evidenced by: cord and agency policy the agency failed to ensure en reviewed at least every # 1) of 1 record reviewed of or greater than 60 days I to affect all of the agency's services longer than 60  mber 1 evidenced a start of The record included a plan by the physician for the 0-17-13 to 12-15-13 and der to continue the skilled e certification period 4. The record failed to care had been reviewed by certification period 12-16-13  ursing, employee A, at 9 AM, the agency's I "crashed" and plans of care ated as a result for some	G 16		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157223	B. WING _				03/2014
	ROVIDER OR SUPPLIER  E HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CO 14649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
G 163 G 170	' "	client illness requires, but at (2) months."	G 1				
	The HHA furnishes skaccordance with the p	killed nursing services in blan of care.					
	Based on clinical rec review and interview, skilled nusring service accordance with phys and 4) of 4 records re	not met as evidenced by: ord and agency policy the agency failed to ensure es had been provided in sician orders in 4 (#s 1, 2, 3, eviewed creating the of the agency's 198 current					
	The findings include:						
	care established by the certification period 0-states, "SN [skilled nuweek for 8 weeks] [medication] regimen dosage, se [side effection]	17-13 to 12-16-13 that urse] 1w x 8 [1 time per . to assess med					
	received 13 different of Director of Nursing, e 1-3-14 at 10:05 AM, the nurse was to fill the planner with these 13 weekly basis.	re identified the patient oral medications daily. The mployee A, indicated, on he plan of care did indicate he patient's medication different medications on a visit note dated 12-10-13					
		· <del>-</del> ·•					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		157223	B. WING		01/03/2014
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  14649 HIGHWAY 41 NORTH, SUITE 200  EVANSVILLE, IN 47725	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
G 170	failed to evidence the B, had filled the pation ordered. The record SN visits had been provided to fill the medication.  2. Clinical record nucare established by certification period 7 record evidenced the discharged from ser of care states, "SN Assess postural signs taken while the and then standing to pressure and pulse with focus on CHF [weight."  A. Skilled nurse 7-25-13, 7-30-13, 8-28-7-13, 8-9-13, 8-108-14-13, evidenced signs while the patie evidence the nurse the patient was lying.  B. The record fa nurse had assessed weeks of 7-21-13 or C. The Director of indicated, on 1-3-14 notes did not eviden postural vital signs a assessed the patient.	e registered nurse, employee ent's medication planner as a failed to evidence any other provided the week of 12-7-13 planner.  Imber 2 included a plan of the physician for the -20-13 to 9-17-13. The expatient had been vices on 9-17-13. The plan I week 2; 2 week 2; 1 week 6 vital signs [a series of vital expatient is lying down, sitting expatient is lying down or skilled to evidence the skilled the patient's weight the	G 17	0	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157223	B. WING			1	C 03/2014
	ROVIDER OR SUPPLIER E HOME HEALTH			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 EVANSVILLE, IN 47725	, <u> </u>	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 170	wounds on the both leincluded a dressing of that states, "Left lower gauze over dorsal foot between toes and own over dorsal foot. Cowbulky gauze, and douand dorsal foot."  1.) A SN visit nevidence the SN had between the toes and ordered.  2.) The Director indicated, on 1-3-14 accompleted the dressin ordered.  3. Clinical record nurcare established by the certification period 10 record evidenced the discharged from serv of care states, "SN 2 assess med regin. Assess postural vita.  A. The plan of car received 19 different basis. SN visit notes 11-21-13, 11-27-13, a evidence the SN had set-up as ordered.  B. SN visit notes, 11-13-13, 11-21-13,	ntified the patient had ower legs. The record hange order dated 8-9-13 er leg - Apply petroleum ot. Place alginate strip er toes. Alginate square ver wound area with ABDs, able layer tubigrip E over toes ote dated 8-10-13 failed to applied the Alginate dover the dorsal foot as or of Nursing, employee A, at 11:30 AM, the SN had not ang change on 8-10-13 as on the physician for the location of the physician for the patient had been ices on 12-20-13. The patient had been ices on 12-20-13. The patient had been ices on 12-20-13. The plan week 1; 1 week 8 SN to the nen compliance/set up I signs."	G	170			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		157223	B. WING			01/	03/2014
	ROVIDER OR SUPPLIER  E HOME HEALTH			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4649 HIGHWAY 41 NORTH, SUITE 200 VANSVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 170	evidence the nurse had the patient was lying of the SN had set-up the failed to evidence the was present as requir policy.  4. Clinical record nurstart of care order data "SN 1 day 1 to evaluate med regimen com  A. The record inclicomprehensive assessidentified the SN had medication planner be medications had been failed to evidence the were present as requipolicy.  B. The record inclicomprehensive assessing record failed to include home care services.  C. The record inclication of the SN visit.  D. The Director of indicated, on 1-3-14 anot include a resumption the 1-2-14 SN visit.	at twas sitting but failed to ad taken the vital signs while down or standing.  dated 11-13-13 evidenced a patient's medications but patient and/or caregiver red by the agency's own  anber 4 included a verbal red 12-10-13 that states, are for home care assess apliance/set up."  uded a start of care asment dated 12-10-13 that checked the patient's fox to ensure the aproperly set up. The note patient and/or caregiver irred by the agency's own  uded a resumption of care asment dated 12-24-13. The ean order to resume the luded a SN visit note dated ailed to evidence an order  f Nursing, employee A, at 11:40 AM, the record did ailed to evidence an order to the little of the litt	G	170			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157223	B. WING_			C	
NAME OF PROVIDER OR SUPPLIER  CARE ONE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE  14649 HIGHWAY 41 NORTH, SUITE 200  EVANSVILLE, IN 47725			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE		
G 170	number 3011 states, furnished to clients. care established and doctor of medicine, o chiropractic, ophthalr  6. The agency's 200 Medications" policy r will only pre-fill medi-	9 "Client Plan of Care" policy "Vibrant! services are . following a written plan of periodically reviewed by a steopathy, podiatry, mology [sic] or dentistry."  9 "Safe/Effective Use of number 3029 states, "Nurses planners in the presence of nd will document their	G 1	70			